Defining Resources. Since the goal of means-testing is to distinguish among enrollees according to their ability to bear a greater share of medical costs, it is necessary to use a measure of "means" that captures all of the economic resources available to enrollees. The usual measure is income--defined as periodic receipts in the form of wages, salaries, interest, dividends, rent, pensions, annuities, and cash benefits such as Supplemental Security Income (SSI) or Social Security. This measure of income captures most of the flows of resources into a household during a year. It may not, however, fully reflect ability to purchase medical care.

An important source of ability to purchase medical care is the asset holdings of a family in the form of savings, securities, or ownership of a home. Such assets are particularly important for the elderly--more than 70 percent of whom own homes and over two-thirds of whom have income from liquid assets. Families with equal levels of income may have very different levels of assets--and hence different resources from which to draw for medical care. The form of the assets may also matter. A $100,000 fully owned home is less liquid than $100,000 in a savings account. It might be necessary, therefore, to add a separate asset test in conjunction with the income test as many existing means-tested programs do.

In addition, families with equal incomes and assets may not be alike in terms of the demands, both medical and otherwise, placed on their resources. Families of different size face different expenditure needs for food and housing. Moreover, for an elderly couple, large medical bills for one spouse are more difficult to pay if the other also has high medical expenses.

Measuring Resources. Every additional complication in the definition of resources adds to the intrusiveness and expense of means-testing. The simpler the definition, the more likely that the means test can be uniformly applied--and the more likely that it will fail to distinguish well among those with different abilities to pay medical bills.

The goal of a simple definition of economic resources or "well-being" can best be met by a measure that corresponds to other commonly used definitions. For example, income reported for tax purposes to the Internal Revenue Service is such a measure, although it varies substantially from a comprehensive measure of income. In the case of the elderly and disabled, the largest source of difference is likely to be Social Security, other transfer payments or pension benefits excluded from taxable income, and other tax-free investment income. These exclusions substantially understate income for Medicare beneficiaries; indeed, many of the aged do not file federal income tax forms since they owe no tax.

A means test could be developed based on adjusted gross income from the income tax form, or perhaps adjusted gross income plus Social Security and other untaxed income. Another possibility would be to use the more complicated reporting required for participation in SSI. Any measure chosen, however, is likely to treat some portion of the elderly and disabled differently from another. For example, using adjusted gross income plus cash transfer payments--thereby ignoring the value of assets--would apply the same out-of-pocket medical costs to persons with high levels of wealth as to those with equal income but no assets. Moreover, since the definition would normally be based on the previous year's income, additional distortions would likely arise.

Establishing a Structure for the Means Test. Some means tests (such as that for Medicaid) establish a dollar level below which benefits are available and above which they are not. In other cases, the cutoff point is phased in to avoid problems of discontinuity in benefits around the cutoff. For Medicare, means-testing could be implemented as differential amounts of coinsurance or deductibles. Alternatively, a cap on total liability could be imposed differentially, depending upon income level.

The simplest approach would be to use only one or two cutoff points, although this would necessarily create discrepancies in coverage between those just above and just below a cutoff. If the difference in benefits was great, persons with high expenses just above the cutoff could be worse off than persons just below the threshold. Using several cutoffs would allow slower gradations of benefits and reduce the discrepancies. A further refinement would be to set the cutoff as a percentage of the defined level of resources, so that it would vary continuously with a measure of income.

On the other hand, with only one or two cutoffs, a means-test could be further simplified by making it voluntary. That is, persons could be subject to the highest level of cost-sharing unless they applied for a lower rate that would require verification of income (and perhaps assets) below a certain limit. In this way, only persons applying for the preferential rate would have to be certified. Those with resources above the established limit (or who chose not to apply) would not need to reveal their incomes. The voluntary principle could also be applied if the liability limit was phased in gradually above the initial resource cutoff.

In fact, such a scheme could be implemented outside the Medicare program entirely, technically avoiding the issue of means-testing Medicare benefits. Medicaid currently provides protection for some very-low-income persons through its medically needy program. That could be expanded to

cap patient liability for moderate-income elderly and disabled, although such an approach would require a number of complicated changes.[16]

Finally, the higher the liability cutoff, the lower would be the total federal savings generated from cost-sharing. If the first cutoff was set relatively high, say at $20,000 of income, the use of a means test might be less controversial. Since many of the elderly and disabled have relatively low incomes, however, a high cutoff would also substantially reduce the federal savings generated. For example, it is projected that by 1984 only 32 percent of the elderly will be in families with incomes over $20,000. Moreover, as shown in Chapter III, use of medical care is lower on average for those in the highest income categories so that savings generated would be less than proportional to the size of the affected group.

16. For example, some major restructuring of Medicaid would be necessary since it is administered by the states and one portion of Medicaid--the medically needy program--is provided at their discretion. Currently, 29 states have programs for the medically needy.

CHAPTER V. OPTIONS FOR RESTRUCTURING MEDICARE BENEFITS

This chapter presents specific options for changing the structure of Medicare benefits. They would affect different groups of Medicare enrollees, distribute the burden in different ways, and generate varying amounts of total federal savings. Some changes would generate savings through increased cost-sharing by enrollees. Others would protect enrollees from excessively high costs as a result of catastrophic illness.

The description of each set of options briefly outlines some of the advantages and disadvantages of concentrating on that specific area of cost-sharing. It shows how individual elderly enrollees would be affected by increases in cost-sharing--that is, how much the actual premiums, coinsurance, and deductible amounts would rise under various options--and to what extent enrollees would be cushioned by benefits from Medicaid or private insurance (other than that purchased by the family).[1] The last section of the chapter presents the federal savings from each option.

RAISING PREMIUMS

Broadly defined, an increase in the SMI premium or the introduction of an HI premium could be considered an increase in cost-sharing. The chief effect would be to raise costs evenly across enrollees, unless the increase was so great as to discourage people from purchasing such coverage.

Raising the SMI Premium

Current SMI premiums cover 25 percent of program costs for aged enrollees. If they were increased enough to cover 35 percent of the costs, premiums would rise to $20.00 per month on January 1, 1984, rather than $14.30 as is now projected. The premium would be adjusted again the following January to maintain the 35 percent share. Except for those who now forgo SMI coverage and enrollees whose premiums are paid for them by Medicaid,[2] costs would rise by $68 in calendar year 1984.

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1. This latter adjustment is consistent with the adjustment used to estimate individual liability for the elderly in Chapter III.

2. Medicaid recipients who are eligible because of SSI participation generally have their SMI premiums paid by Medicaid, while many of the medically needy do not.

This option would result in the most even distribution of increased costs among enrollees of all the options discussed in this chapter, and would not raise costs substantially for those already facing large medical bills. Inevitably it would place a greater burden on low- and moderate-income enrollees than on high-income enrollees. Moreover, it would not generate indirect savings by reducing the use of medical care.

Introducing a Premium for HI

Under current law, those eligible for coverage under HI pay no premium even though the average benefits they receive are much greater than their contributions during their working years. Cost-sharing based on the use of services would be concentrated on a minority of enrollees since only about one-fourth of them use HI-covered services in a given year.

Additional enrollee contributions could be obtained through the imposition of a monthly HI premium of $10 beginning January 1, 1984, and increasing each January at the same rate as the HI deductible amount. Enrollees would pay $120 in calendar year 1984--representing less than 10 percent of average per capita HI reimbursements for the elderly.

Like the SMI premium, the costs of greater cost-sharing would thus be spread across all enrollees rather than concentrated on those who face periods of hospitalization or institutional care. The latter already pay considerable cost-sharing--from SMI and from HI deductibles and coinsurance.

INCREASING THE SMI DEDUCTIBLE AMOUNT

Another relatively simple change in Medicare's benefit structure would be to increase the deductible amount for SMI services. Like changes in the SMI premium, increases in the SMI deductible amount would be spread over a broad range of the covered population.

The deductible amount for SMI has only been increased twice since Medicare began serving beneficiaries in 1966. First set at $50 per year, it is now 50 percent higher ($75 per year). Between 1967 and 1980, however, average per capita reimbursements for the elderly under SMI grew 328 percent and even household income more than doubled over the period.

Increasing the SMI deductible to $100 on January 1, 1984, and indexing it thereafter to the rate of growth of per capita SMI reimbursements would raise average Medicare cost-sharing for the elderly by about $13 in calendar year 1984. This would be unlikely to reduce participation in SMI. The

nearly 70 percent of beneficiaries who now exceed the deductible would pay all or part of the additional $20.[3] While, as with the increased SMI premium, the absolute increase would be similar for all beneficiaries, this option would have the greatest relative impact on those with the lowest incomes (who are not also covered by Medicaid).

CHANGING COINSURANCE

Changes in coinsurance could be introduced in Medicare by raising the share of costs paid by beneficiaries on services that have coinsurance, and by extending coinsurance to areas that currently require no patient cost-sharing. The options presented in this section consider such changes for only one category of medical care at a time in order to focus on the impact of each. Combinations of changes are considered in the next section.

SMI Coinsurance

At present, SMI enrollees must pay 20 percent coinsurance for all SMI covered services except home health care. This is the largest source of beneficiary liability for Medicare-covered services.[4] If no changes in the benefit structure were to occur in 1984, SMI coinsurance would represent about 80 percent of average Medicare cost-sharing liability for the elderly and disabled. Hence increasing SMI coinsurance could be expected to have a significant impact on Medicare outlays--the more so since, as discussed in Chapter IV, use of medical services of all types may be sensitive to increased coinsurance on physicians' services.

Increasing the coinsurance rate to 25 percent would raise average per capita beneficiary cost-sharing by $40 for the elderly and $54 for the disabled. For the approximately 70 percent of enrollees who now pay coinsurance, the added costs would not substantially change the distribution

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3. Since beneficiaries pay 20 percent of all reasonable charges, they would already pay $5 of the $25 difference in the deductible that would result if it were raised to $100.

4. Additional charges assessed by physicians on Medicare enrollees may actually be higher. In 1975, physicians' unassigned claims were estimated to average about two-thirds of the amount of physician coinsurance paid by the elderly. Since that time, the size of submitted charges relative to allowed charges has grown, although these submitted charges do not necessarily reflect what patients pay on unassigned claims.

of beneficiaries by level of Medicare cost-sharing (see Table 13).[5] They would, however, tend to shift enrollees at all levels into slightly higher cost-sharing categories.

When these increases are calculated by income group, there is little consistent variation. Those with incomes under $5,000 would pay a little less, on average, than those with higher incomes, if the liability was adjusted to reflect the contribution of Medicaid coverage.

Hospital Coinsurance

Although Medicare currently assesses coinsurance on hospitalization, these charges do not go into effect until the sixty-first covered day of a particular benefit period. About 0.6 percent of enrollees pay coinsurance in any year. For those who do pay, however, the costs can be very high.

The hospital coinsurance options discussed here would change the period for assessing deductibles and coinsurance from a "spell of illness" to an annual basis. The deductible would be assessed on the first day of a hospital stay in any given year, and coinsurance days would be calculated on the annual total regardless of number of stays. That is, the deductible and coinsurance assessments would be identical for two beneficiaries with equal numbers of covered days in the hospital but with unequal numbers of stays.[6] Such a change would protect beneficiaries from liability for more than one hospital deductible or set of coinsurance charges in any given year. Moreover, enrollees would know with more certainty what their liability would be. On the other hand, those with multiple hospital stays in December and January would be assessed the deductible twice.

Two hospital coinsurance options, both of which would replace current coinsurance and begin January 1, 1984, are considered here. The first option would assess a coinsurance rate on each hospital day (after the first day, which is subject to the deductible) of 10 percent of the deductible amount. The second option would limit that coinsurance to 29 days. That is, after

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5. Data for the disabled, and additional results for the elderly, are presented in Appendix F.

6. The average increase in cost-sharing required of beneficiaries would change little if this was the only adjustment in coverage. For individuals, however, differences would arise since some enrollees with hospital stays now pay no deductible in a given year while others (with multiple benefit periods) pay more than once.

TABLE 13. THE DISTRIBUTION OF ENROLLEES BY LEVEL OF MEDICARE COST-SHARING UNDER CURRENT LAW AND FOR THREE COINSURANCE OPTIONS (In percents and 1984 dollars)

Amount of Total Medicare Cost-Sharing	Current Law	25 Percent SMI Coinsurance	Full 10 Percent Hospital Coinsurance	10 Percent Hospital Coinsurance on Days 2-30
Percentage of Enrollees in Each Category				
$0 - $300	51.4	50.1	51.4	51.4
$301 - $500	22.6	21.9	22.4	22.4
$501 - $1,000	14.6	14.9	9.7	9.7
$1,001 - $2,000	9.1	10.1	11.4	11.7
$2,001 - $3,000	1.3	1.9	3.1	3.5
$3,001 - $4,000	0.4	0.6	1.0	0.8
More than $4,000	0.4	0.5	0.9	0.4
Average Increased Cost-Sharing				
Average Increase in Cost-Sharing for All Enrollees	--[a]	40	72	52
Average Increase for Those Whose Cost-Sharing Rises	--[a]	58	443	375
(Percent of enrollees experiencing increases)	--[a]	(70.0)	(19.8)	(19.5)
Average Decrease for Those Whose Cost-Sharing Falls	--[a]	0	-2,137	-2,119
(Percent of enrollees experiencing decreases)	--[a]	(0)	(0.8)	(1.0)

SOURCE: Congressional Budget Office simulations from the Medicare History Sample.

a. Not appropriate.

the first 30 days of hospitalization in any year, no additional hospital cost-sharing would be required. For 1984, the 10 percent coinsurance amount would be approximately $35 per day (assuming no change in the calculation of the deductible amount) and could be expected to have some effect on the use of hospital services by those without Medicaid or private insurance.

While few persons are currently subject to coinsurance, the relatively high charges that are assessed in such circumstances would result in an important offset in savings even under the full 10 percent coinsurance option. For a person hospitalized for 150 days in 1984 (and assuming the beneficiary has not used any lifetime reserve days), the deductible and coinsurance under the full 10 percent option would total $5,597 compared to $13,552 under the current benefit structure. Moreover, this excludes the impact of the changes on hospital days not now covered because benefits have been exhausted. The estimates presented in the chapter do include an adjustment for those exhausted days.[7] The more restricted option of cost-sharing for only the first 30 days would cost that beneficiary only $1,373. In this case, however, those facing lower cost-sharing might expand their use of medical services.

Placing a limit on the number of days subject to coinsurance would restrict the average increase in cost-sharing to $52 as compared to $72 under the full 10 percent option (see Table 13).[8] When this average is further disaggregated to show the mean increase for those whose cost-sharing rises and the mean decrease for those whose cost-sharing falls, the source of the difference in the two options is even clearer. The limited 10 percent hospital coinsurance would lower overall Medicare cost-sharing for the small number of beneficiaries now paying coinsurance (on days 61 through 150) by an average of $913 or by $2,119 if days that were now uncovered are included.

Under both hospital coinsurance options, those with out-of-pocket costs below $300 would be unaffected, while those with higher liabilities would be more likely to face increased costs as compared with current law (see Table 13). The full 10 percent option would almost double the number of enrollees with Medicare cost-sharing in excess of $2,000. Other beneficiaries, with more moderate costs under current law, would also move

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7. This figure would be very large for a small number of beneficiaries since each hospital day would cost about $376 on average. Across all enrollees, it is estimated that the cost of such coverage would average about $12 per day.

8. These estimates are based on the 1978 distribution of hospital days, and are consequently somewhat low relative to 1984 projections.

into higher liability categories. The restricted 10 percent option, on the other hand, would reduce the liabilities of enrollees in the very highest category, since they would no longer face the coinsurance that now begins after 60 days. The increased costs under this option would occur for those in the mid-range of current liability levels.

Since hospital use displays a declining--but somewhat inconsistent--pattern at higher income levels, increased individual liability for the full 10 percent coinsurance option would fall somewhat less heavily on those with incomes over $30,000. Changes among income categories would be smaller than changes within a particular income group.

COMBINING COST-SHARING OPTIONS

Up to this point various options for cost-sharing have been presented separately. Some of them could be combined to achieve greater savings, a more even distribution of the burden, and improved coordination of cost-sharing. Some coordination of changes might be necessary to achieve a balance in the use of different types of services, since each change would affect incentives to use specific services. For example, higher coinsurance on skilled nursing facilities could discourage beneficiaries from moving out of inpatient hospital care to a skilled nursing facility unless hospital coinsurance was also increased. Other changes might have offsetting effects. For instance, if SMI coinsurance rates were raised, an increase in SMI premiums tied to a share of total costs would be less than if SMI benefits remained the same. Thus the changes discussed here are not necessarily additive.

For illustrative purposes, three combinations will be considered:

- A combination of 10 percent hospital coinsurance on days 2 through 30 of a year's hospitalization and an increase in SMI premiums to cover 35 percent of costs;

- A combination of 10 percent hospital coinsurance with an increase in SMI coinsurance to 25 percent; and

- A combination of 10 percent hospital coinsurance, 5 percent skilled nursing facility (SNF) coinsurance, and coinsurance on home health of 10 percent of the charge for each visit.

The hospital coinsurance and SMI components of these three options are based on changes already discussed in more detail earlier in this chapter. In the first of these combinations, hospital coinsurance of 10 percent of the deductible amount would be applied only on days 2 through 30 of hospital

stays in a calendar year. In the other two options, no upper bound would be placed on the number of days. The SMI increase would be tied to the average costs for an aged enrollee.

The third option would introduce two changes not previously discussed, which would affect skilled nursing and home health benefits. The skilled nursing coinsurance change is analogous to the hospital coinsurance options already considered; coinsurance would be assessed on each covered day (rather than only after 20 days), but at a lower 5 percent of the hospital deductible amount (compared to the current 12.5 percent rate). Coinsurance on home health visits would also be added and set at 10 percent of the charge for each visit. Currently, no cost-sharing is required for home health care.

The first combined option would increase cost-sharing by more than the other two alternatives, although its effects would be the most evenly distributed (see Table 14). Persons who currently pay hospital coinsurance as a result of extended periods of hospitalization would be considerably better off than under the current structure, where their HI liability can be very high. The average reduction for such beneficiaries would be $2,343 per year--but only a small proportion of beneficiaries would have a decline in cost-sharing.

The combination of hospital and SMI coinsurance changes (combination option 2) would also increase average Medicare cost-sharing substantially, since these cost-sharing changes would affect 96 percent of all Medicare reimbursed services. Since high users of HI services are also likely to have high SMI expenses, cost-sharing for those with hospital stays would increase dramatically under this option. As indicated in Table 14, the proportion of the elderly with cost-sharing in excess of $3,000 would almost triple. Those with hospital stays of at least 20 days would have an average increase in cost-sharing of $911 for example.

The third combination option would increase the number of beneficiaries with cost-sharing under $300 and over $1,000, compared to current law. The hospital coinsurance change would largely be responsible for increased cost-sharing at the upper end. The increase in beneficiaries at the bottom of the distribution would result because some beneficiaries would pay lower coinsurance on SNF benefits and some of those who receive SNF care have low levels of other types of cost-sharing liability. Although SNF coinsurance would be extended to all 100 days, the lower daily amount ($17.60 versus $44 in 1984) would mean that a person hospitalized all 100 allowable days would pay only about half as much in coinsurance under this option. This lower SNF coinsurance was chosen for the combination option since SNF care is less expensive than short-stay hospital care and the coinsurance for such hospital stays would be 10 percent (rather than the 25

TABLE 14. THE DISTRIBUTION OF ENROLLEES BY LEVEL OF MEDICARE COST-SHARING UNDER CURRENT LAW AND FOR THREE COMBINATION OPTIONS (In percent and 1984 dollars)

Amount of Total Medicare Cost-Sharing	Current Law	Hospital Coinsurance and Increased SMI Premium[a]	10 Percent Hospital Coinsurance and 25 Percent SMI Coinsurance[a]	Coinsurance Changes on Hospitals, SNFs, and Home Health[a]
Percentage of Enrollees in Each Category				
$0 - $300	51.4	42.2	50.1	55.9
$301 - $500	22.6	27.3	21.7	19.1
$501 - $1,000	14.6	12.8	10.8	8.5
$1,001 - $2,000	9.1	12.6	11.4	11.4
$2,001 - $3,000	1.3	3.9	3.7	3.1
$3,001 - $4,000	0.4	0.8	1.2	1.1
More than $4,000	0.4	0.4	1.1	0.9
Average Increased Cost-Sharing				
Average Increase in Cost-Sharing for All Enrollees	--[b]	120	112	74
Average Increase for Those Whose Cost-Sharing Rises	--[b]	142	183	444
(Percent of enrollees experiencing increases)	--[b]	(99.1)	(69.5)	(20.4)
Average Decrease for Those Whose Cost-Sharing Falls	--[b]	-2,343	-3,313	-2,003
(Percent of enrollees experiencing decreases)	--[b]	(0.9)	(0.5)	(0.8)

SOURCE: Congressional Budget Office simulations from the Medicare History Sample.

a. See text for a more detailed definition of the option.
b. Not appropriate.

or 50 percent now in effect for extended stays). To maintain the incentive for persons to move out of hospitals and into SNF facilities whenever feasible, it would be important to ensure that out-of-pocket costs to patients are lower for SNFs.

COMBINING MEDICARE COST-SHARING WITH IMPROVED CATASTROPHIC PROTECTION

Increases in Medicare cost-sharing could place large burdens on some beneficiaries. Particularly in the case of hospital coinsurance, even a modest daily charge added to the present system could result in very high liability for the small minority of patients with extended hospital stays--and who have no supplemental protection. Placing a cap on such liability would protect them from catastrophic charges, thus alleviating one major concern about increased cost-sharing.

Once such a limit was reached, however, patients would have access to additional services at no cost. For these patients, the impact of coinsurance would be lost. Moreover, if the limits were set at a relatively low level, a large portion of the direct federal savings would also be lost. Finally, for persons who purchase private supplemental insurance coverage, limits on liability would lower their insurance premiums (by lowering the insurance company's risk), but would not increase protection against extraordinary expenses. The number of beneficiaries above some cost-sharing limit (in excess of $2,000) would be small under any circumstances, and if only the privately uninsured were of concern the proportion of affected beneficiaries would be even smaller. Consequently, the cost of a cap per affected beneficiary would be very high.

Separate SMI and HI Limits on Patient Liability

Since the SMI and HI portions of Medicare are administered separately, one approach would be to place separate limits on the cost-sharing liability generated by each. This could lower the administrative costs of such a cap. But the separate caps would have to be higher, when added together, than one combined limit in order to achieve the same level of savings. Some individual beneficiaries would consequently be worse off than under a combined cap while others would gain.

Alternatively, since much of the dispersion in cost-sharing liability is attributable to those with long hospital stays, the imposition of a cap could be limited to HI cost-sharing, particularly if the only other benefit change was in the structure of hospital coinsurance. The HI limit could be lower than a limit on both HI and SMI, recognizing the potentially high SMI costs.

Placing a limit on the number of hospital days subject to coinsurance (as discussed earlier in this chapter) implicitly acts as such a cap for most HI services. The small number of enrollees receiving SNF care means that few persons would reach a cap of, say, $1,500 from SNF services alone. At the projected coinsurance of $44 per day in 1984, the maximum coinsurance payable would be $3,520.

On the other hand, Medicare participants with extended hospital stays often have unusually high SMI expenses as well--even in excess of any physicians' services charged specifically during a hospital stay. The relatively high 20 percent coinsurance on SMI services would mean that total cost-sharing expenses would remain very high for beneficiaries reaching the limit on HI liability.

Limits on Total Medicare Cost-Sharing

The effect of an overall limit on HI and SMI cost-sharing would depend on the level of that limit and on what other changes were made in the deductible amounts and coinsurance.[9] Table 15 summarizes the average per capita cost-sharing increases for elderly enrollees from four possible cost-sharing limits, when combined with the option of 10 percent hospital coinsurance beginning the second day of a hospital stay.[10] The limits range between $1,000 and $4,000. Below the applicable limits, the distribution of beneficiaries would be the same as for the full 10 percent hospital coinsurance option (see Table 13). The imposition of a $2,000 limit, for example, would move the 5 percent of elderly enrollees who would otherwise exceed that limit down into the top of the $1,000 to $2,000 bracket (see Table 13).

Elderly enrollees would, on average, have a decrease in cost-sharing liability of $81 with a $1,000 cap and 10 percent hospital coinsurance. At a limit of $1,000, about one-sixth of all elderly enrollees would be subject to the cap. The savings to such individuals would be high enough to result in a

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9. In this analysis, cost-sharing is assumed to include SMI premiums as well as all Medicare coinsurance and deductible amounts. It excludes, however, any estimate of additional liability to beneficiaries from the costs of excess charges not allowed under SMI.

10. As described earlier in this chapter, the coinsurance would be 10 percent of the deductible amount; this deductible would continue to be assessed on the first hospital stay in any year; and the current coinsurance on days 60 through 150 would be eliminated.

TABLE 15. EFFECT OF 10 PERCENT HOSPITAL COINSURANCE ON ELDERLY ENROLLEES UNDER VARIOUS COST-SHARING LIMITS (In percents and 1984 dollars)

	Options Including 10 Percent Hospital Coinsurance and Limits of:				
	$1,000	$2,000	$3,000	$4,000	No Limit
Percentage of Elderly Enrollees Subject to the Limit	16.4	5.0	1.9	0.9	--
Average Increase in Cost-Sharing Over Current Law	-81	15	46	59	72
Average Increase for Those Whose Cost-Sharing Rises	143	314	389	420	443
(Percent of enrollees experiencing increases)	(9.7)	(17.9)	(19.1)	(19.5)	(19.8)
Average Decrease for Those Whose Cost-Sharing Falls[a]	-841	-1,542	-2,013	-2,316	-2,137
(Percent of enrollees experiencing decreases)[a]	(11.3)	(2.7)	(1.4)	(1.0)	(0.8)

SOURCE: Congressional Budget Office simulations from the Medicare History Sample.

a. The decreases shown here generally average smaller the lower the limit because additional numbers of enrollees are affected and their smaller decreases in cost-sharing lower the overall average.

decrease in average cost-sharing as compared to current law. By 1984, over 11 percent of beneficiaries would have cost-sharing in excess of $1,000 even with no changes in current law.

At $2,000, the average cost-sharing increase from the hospital coinsurance option would drop by almost 80 percent as compared to the no-limit option--from $72 to $15. In fact, this limit would actually result in higher per capita reimbursements for the disabled than if no changes (in coinsurance) were implemented since average cost-sharing for the disabled is already quite high. At higher limits, more of the federal savings would be retained. Even with a $4,000 limit, however, per capita liability would only be 82 percent as high as if there were no limit, even though fewer than 1 percent of beneficiaries would be affected.

The effect of the limits is highlighted even more dramatically by focusing on the average for those whose cost-sharing would increase. Moving from a $1,000 limit to a $2,000 limit would more than double the average increase in cost-sharing for affected beneficiaries. The increase would be much smaller, however, between a $3,000 and a $4,000 limit.

If there was no limit on the cost-sharing, fewer than 1 percent of enrollees would face a decline in cost-sharing liability. These would be the enrollees who would be subject to hospital coinsurance under current law. The introduction of limits would increase substantially the number of elderly beneficiaries experiencing declines in Medicare-related cost-sharing. This would result from eliminating both high coinsurance after 60 hospital days and high cost-sharing expenses from combined HI and SMI use.

The increases in liability do not vary consistently by income category. The relative impact of these caps would, of course, be greater for those with incomes under $10,000. That is, even a $2,000 cap on cost-sharing liability might still result in a substantial burden for those with low or moderate incomes who faced high medical expenses and had no private insurance.

Limits Based on Income

In order to achieve both relatively low cost-sharing limits for those with low incomes and substantial federal savings from the cost-sharing increase, limits could be varied by level of income. For purposes of illustration, the first option considered here would place a $2,000 limit on cost-sharing for enrollees with 1983 family incomes below $20,000, and a $4,000 limit for those with incomes above $22,000. For those with family incomes between $20,000 and $22,000, the liability limit would rise (above $2,000) by one dollar for every dollar in income in excess of $20,000. This

would allow a phase-in of the changes in cost-sharing liability, thereby eliminating problems with discontinuity of benefits. The second option would similarly establish limits between $1,500 and $3,000, again with the initial cutoff at $20,000 of family income.[11] For simplicity, the standard definition of income is used with no adjustment for other resources or differences in family size. Approximately 68 percent of the noninstitutionalized elderly would have incomes below $20,000 in 1983.

Among all elderly enrollees cost-sharing would rise by an average of $29 for the first option and by $10 in the second case. Under both these options, this increase in cost-sharing liability would be higher, on average, for those with incomes over $20,000 in 1984 than for those with lower incomes. Some beneficiaries in the lower income groups would likely have cost-sharing liabilities representing a substantial share of their family income even if the cap was set at $1,500, however.

FEDERAL SAVINGS

With one exception, all of the specific options discussed in this chapter would result in federal outlay savings in 1984 and beyond (see Table 16). The savings would not, however, correspond directly to the estimated increases in per capita cost-sharing for elderly enrollees described in the earlier sections of this chapter. Disabled beneficiaries would have different amounts of per capita increases. Moreover, adjustments must be made for Medicaid offsets and changes in behavior induced by higher coinsurance and deductibles.

As discussed in Chapter IV, the behavioral changes that could be expected under Medicare from changes in the benefit structure are relatively small because, for about 70 percent of the beneficiaries, Medicare's coinsurance and deductibles are covered through Medicaid and private supplemental insurance. These indirect effects would vary considerably among the options. Some of the benefit structure changes--such as limits on total cost-sharing liability--could even stimulate increased use of medical services.

The highest five-year savings would be generated by two of the combination options and the introduction of an HI premium. Even these options generate five-year savings of less than $30 billion, however, and would make only a minor contribution to solving the financing problems facing HI. The second combination--SMI and hospital coinsurance increases--

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11. In this case, the maximum $3,000 limit would begin for those with incomes at $21,500 and above.

TABLE 16. FEDERAL OUTLAY SAVINGS FROM OPTIONS CHANGING THE MEDICARE BENEFIT STRUCTURE, FISCAL YEARS 1984-1988 (In billions of dollars)[a]

Option[b]	1984	1985	1986	1987	1988	5-Year Total
SMI Premium Increase	1.4	2.1	2.7	3.7	4.8	14.8
HI Premium	2.5	3.6	4.1	4.8	5.4	20.3
SMI Deductible Increase	0.2	0.5	0.8	1.1	1.5	4.1
SMI Coinsurance of 25%	0.6	1.3	1.6	1.9	2.2	7.7
Hospital Coinsurance of 10% of Deductible	1.7	2.9	3.4	3.9	4.4	16.2
With $1,000 limit	-1.9	-3.4	-3.9	-4.5	-5.1	-18.8
With $2,000 limit	0.3	0.5	0.5	0.6	0.7	2.6
With $3,000 limit	1.0	1.8	2.1	2.4	2.7	9.9
With $4,000 limit	1.3	2.3	2.7	3.1	3.5	13.0
With $2,000 limit for those with incomes below $20,000; rising thereafter to $4,000	0.6	1.0	1.2	1.3	1.5	5.5
With $1,500 limit for those with incomes below $20,000; rising thereafter to $3,000	0.1	0.2	0.2	0.3	0.3	1.1
Hospital Coinsurance of 10% of Deductible Days 2-30	1.2	2.1	2.5	2.8	3.2	11.9
Combination Option 1	2.6	4.2	5.2	6.5	8.0	26.5
Combination Option 2	2.3	4.2	5.0	5.8	6.6	23.9
Combination Option 3	1.8	3.2	3.7	4.2	4.8	17.7

SOURCE: Congressional Budget Office simulation from Medicare History Sample.

a. Savings in each of these options are estimated independently of any other change and hence the various options usually cannot be added.
b. For detailed descriptions of these options, see the text.

would produce a greater proportion of its savings indirectly through lower use of both SMI and hospital services. The first combination includes an increase in the SMI premium, which would not affect behavior.

Changes in the SMI deductible amount would generate low federal savings. The option as defined here would increase cost-sharing by only a small amount for each affected beneficiary. The option is of particular interest since it bridges the gap between a premium increase--affecting all beneficiaries--and greater coinsurance that would place proportionately greater costs on the high users of care. Deductible changes affect only the users of care, but by a limited amount.

Savings from three of the options would be quite comparable in 1984--ranging from $1.2 to $1.4 billion. These options are the increase in the SMI premium, the limited change in hospital coinsurance, and hospital coinsurance with a $4,000 cap on cost-sharing. They would do so, however, at the expense of different groups within the population. The SMI premium would affect all enrollees, while both hospital coinsurance options would raise costs to only about one-quarter of all enrollees.

Finally, it is interesting to compare the changes in federal savings under the various cost-sharing limits. Savings would increase substantially--by $0.7 billion--between the $2,000 and $3,000 limits, but moving the limit out further to $4,000 would generate only an additional $300 million in federal savings in fiscal year 1984. Since the limited hospital coinsurance option also implicitly represents a type of cap, it is notable that a combined cap would have to be set at over $4,000 to result in equivalent savings.

APPENDIXES